

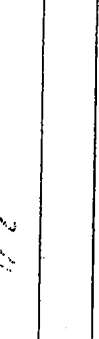



| DOCTOR'S ORDER SHEET |           | DRUG SENSITIVITIES: |                | NONE KNOWN    |  |
|----------------------|-----------|---------------------|----------------|---------------|--|
| DOCTOR'S SIGNATURE   | DATE/TIME | NOTED BY            | Medication     | New           | 900105770<br>0004 12/01/94<br>0004 12/01/94<br>0004 12/01/94 |
|                      |           |                     | Dose & Route   | Renew         |  |
|                      |           |                     | Frequency      | Change        |  |
|                      |           |                     | M.D. Signature | Stat.         |  |
|                      |           |                     | Date           | Stop          |  |
|                      |           |                     | Comments       | Time of Order |  |
| DOCTOR'S SIGNATURE   | DATE/TIME | NOTED BY            | Medication     | New           | 900105770<br>0004 12/01/94<br>0004 12/01/94<br>0004 12/01/94 |
|                      |           |                     | Dose & Route   | Renew         |  |
|                      |           |                     | Frequency      | Change        |  |
|                      |           |                     | M.D. Signature | Stat.         |  |
|                      |           |                     | Date           | Stop          |  |
|                      |           |                     | Comments       | Time of Order |  |
| DOCTOR'S SIGNATURE   | DATE/TIME | NOTED BY            | Medication     | New           | 900105770<br>0004 12/01/94<br>0004 12/01/94<br>0004 12/01/94 |
|                      |           |                     | Dose & Route   | Renew         |  |
|                      |           |                     | Frequency      | Change        |  |
|                      |           |                     | M.D. Signature | Stat.         |  |
|                      |           |                     | Date           | Stop          |  |
|                      |           |                     | Comments       | Time of Order |  |
| DOCTOR'S SIGNATURE   | DATE/TIME | NOTED BY            | Medication     | New           | 900105770<br>0004 12/01/94<br>0004 12/01/94<br>0004 12/01/94 |
|                      |           |                     | Dose & Route   | Renew         |  |
|                      |           |                     | Frequency      | Change        |  |
|                      |           |                     | M.D. Signature | Stat.         |  |
|                      |           |                     | Date           | Stop          |  |
|                      |           |                     | Comments       | Time of Order |  |

USE BALLPOINT PEN PRESS FIRMLY

CHART COPY

006049

| DOCTOR'S ORDER SHEET  |  | DRUG SENSITIVITIES: |         | NONE KNOWN <input type="checkbox"/> |  |
|---|--|---------------------|---------|-------------------------------------|--|
| <b>1</b><br><br>DOCTOR'S SIGNATURE    |  | DATE/TIME           | 4/13/94 | NOTED BY                            |  |
|   |  | Medication          |         |                                     |  |
|   |  | Dose & Route        |         |                                     |  |
|   |  | Frequency           |         |                                     |  |
|   |  | M.D. Signature      |         |                                     |  |
| <b>2</b><br><br>DOCTOR'S SIGNATURE   |  | DATE/TIME           | 4/13/94 | NOTED BY                            |  |
|   |  | Medication          |         |                                     |  |
|   |  | Dose & Route        |         |                                     |  |
|   |  | Frequency           |         |                                     |  |
|   |  | M.D. Signature      |         |                                     |  |
| <b>3</b><br><br>DOCTOR'S SIGNATURE   |  | DATE/TIME           | 4/13/94 | NOTED BY                            |  |
|   |  | Medication          |         |                                     |  |
|   |  | Dose & Route        |         |                                     |  |
|   |  | Frequency           |         |                                     |  |
|   |  | M.D. Signature      |         |                                     |  |
| <b>4</b><br><br>DOCTOR'S SIGNATURE |  | DATE/TIME           | 4/13/94 | NOTED BY                            |  |
|   |  | Medication          |         |                                     |  |
|   |  | Dose & Route        |         |                                     |  |
|   |  | Frequency           |         |                                     |  |
|   |  | M.D. Signature      |         |                                     |  |

USE BALLPOINT PEN PRESS FIRMLY

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000001

NR 1613 8/82

MONTEFIORE MEDICAL CENTER

VITAL SIGNS - GRAPHIC SHEET

- RECORD (1) TEMPERATURE READING IN RED  
 (2) PULSE AND RESPIRATION READING IN BLUE  
 (3) BLOOD PRESSURE - V SYSTOLIC  
                           - A DIASTOLIC IN BLUE

900105770

7579740 GILADI, RONI  
 POB 27 MTLBOURNE NJ 07041  
 P. B. STRAUCH, PLS  
 112643264 M39 H 011-972-5334  
 06443890 0003B121291

| DATE           |        |       | 12/12 |   |    |   | 13 |    |    |   | 14 |   |    |    | 15 |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
|----------------|--------|-------|-------|---|----|---|----|----|----|---|----|---|----|----|----|---|----|---|----|----|----|---|----|---|----|----|----|---|----|---|---|----|
| TEMP. MODE     |        |       |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| A.M. OR P.M.   |        |       | AM    |   | PM |   | AM |    | PM |   | AM |   | PM |    | AM |   | PM |   | AM |    | PM |   | AM |   | PM |    | AM |   | PM |   |   |    |
| HOUR           |        |       | 4     | 8 | 12 | 4 | 8  | 12 | 4  | 8 | 12 | 4 | 8  | 12 | 4  | 8 | 12 | 4 | 8  | 12 | 4  | 8 | 12 | 4 | 8  | 12 | 4  | 8 | 12 | 4 | 8 | 12 |
| BLOOD PRESSURE | TEMP F | PULSE |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 250            | 106°   | 180   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 240            | 105°   | 170   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 230            | 104°   | 160   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 220            | 103°   | 150   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 210            | 102°   | 140   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 200            | 101°   | 130   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 190            | 100°   | 120   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 180            | 99°    | 110   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 170            | 98°    | 100   |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 160            | 97°    | 90    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 150            | 96°    | 80    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 140            | 95°    | 70    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 130            |        | 60    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 120            |        | 50    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 110            |        | 40    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 100            |        | 30    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 90             |        | 20    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 80             |        | 10    |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 70             |        |       |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 60             |        |       |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 50             |        |       |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 40             |        |       |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| 30             |        |       |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| CVP            |        |       |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |
| WEIGHT         |        |       |       |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |    |    |    |   |    |   |   |    |

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000053

[illegible]

NR-7922M

Montefiore Medical Center  
Moses Division  
Same Day Care Center  
Nursing Assessment/Admission Interview

3000-RB 900105770  
CILADI, RONI  
PCB127MILBOURNE NJ07041  
B. STRAUCH PLS  
112-64-3264 39 H 03/05/52  
06443890 0004 12/09/91

Scheduled procedure: Procedure Information Amb or SDA Date: 12-12-91

Attending Physician: G. Trauch Medical Attending: \_\_\_\_\_

Designated responsible party (Indicate for all procedures)

Name: \_\_\_\_\_ Relationship: SDA

Information obtained from patient \_\_\_\_\_ family \_\_\_\_\_ Interpreter \_\_\_\_\_ by phone \_\_\_\_\_

Pre assessment V/S: T 99° P 76 R 20 B/P 140/78 Ht 5'11" Wt 190 Date: 12-9-91

Allergies: No (circled) Yes \_\_\_\_\_ Unknown \_\_\_\_\_ (if yes, indicate substances)

WKTDO

Past Medical, Surgical, Psychiatric History:

ASA: exc. of OS ptyff  
Trep. (med nerve  
(1987)

PMA: (circled)

Present Medications: Uses aspirin or aspirin products No (circled) Yes \_\_\_\_\_ (specify)

Polypsoni eye ointment OS TID.

Transfusion History: No (circled) Yes \_\_\_\_\_ (please specify)

Smoke? (circled) (no/yes) How much? (circled) How long? (circled)

Substance abuse (alcohol or drugs): (circled)

006056

-3-

E.E.N.T.: Glaucoma, IOL, prosthesis (type & location                     ), current earache/discharge,  
nasal congestion, sore throat, recent URI, voice change, other                     

Neurological: Headaches, tremors, seizures, vertigo, motor deficits                     , sensory  
deficits                     , other                     

Infectious disease: Hepatitis, tuberculosis, AIDS, venereal disease                     ,  
other                     

Mental/Emotional: Anxiety, depression, insomnia, lethargy, hallucinations, disorientation, memory loss, other  
                    

Skin integrity: Lesions, scars, rashes, ecchymosis, decubiti, (describe and give location  
                    ), other                     

**Patient Profile:**

394 old male on  
for E. vent @ ulu  
one

006057

MONTEFIORE MEDICAL CENTER - MOSES DIVISION - DEPARTMENT OF NURSING  
NURSING PROCESS PART 3: PROBLEM LIST

Instructions for evaluation:

1. Each problem/need is assigned its own number and box.
2. Designation for continuation of problem/need from day to day is "-".
3. Resolution of problem/need is designated by "Ø".
4. Change in labeling of problem/need is designated by "Δ".

RN Initial Signature RN Initial Signature

78909105-14001

N78787A GILADI, RONI  
POB127MILBOURNE NJ07041  
P B. STRAUCH PLS

112643264 N39 H 011-972-5334

06443840-00038121291

*Shenando*

| Problem # | DAY #<br>DATE  | DAY #<br>DATE | DAY #<br>DATE | DAY #<br>DATE | DAY #<br>DATE | DAY #<br>DATE | DAY #<br>DATE | DAY #<br>DATE | DAY #<br>DATE | DAY #<br>DATE |
|-----------|--|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| 1         | 12/18<br>Attention<br>in comfort<br>RT pain                                  |               |               |               |               |               |               |               |               |               |
| 2         | 12/18<br>Pot. Attention<br>in circulatory<br>status RT of<br>disease process |               |               |               |               |               |               |               |               |               |
| 3         | 12/18<br>Pot. for<br>infection<br>RT invasive<br>procedure                   |               |               |               |               |               |               |               |               |               |
| 4         | 12/18<br>Pot. for<br>post-op<br>respiratory<br>status                        |               |               |               |               |               |               |               |               |               |
| 5         |  |               |               |               |               |               |               |               |               |               |
| 6         |  |               |               |               |               |               |               |               |               |               |
| 7         |  |               |               |               |               |               |               |               |               |               |
| 8         |  |               |               |               |               |               |               |               |               |               |
| 9         |  |               |               |               |               |               |               |               |               |               |
| 10        |  |               |               |               |               |               |               |               |               |               |
| 11        |  |               |               |               |               |               |               |               |               |               |
| 12        |  |               |               |               |               |               |               |               |               |               |
| 13        |  |               |               |               |               |               |               |               |               |               |
| 14        |  |               |               |               |               |               |               |               |               |               |
| 15        |  |               |               |               |               |               |               |               |               |               |
| 16        |  |               |               |               |               |               |               |               |               |               |
| 17        |  |               |               |               |               |               |               |               |               |               |
| 18        |  |               |               |               |               |               |               |               |               |               |
| 19        |  |               |               |               |               |               |               |               |               |               |
| 20        |  |               |               |               |               |               |               |               |               |               |
| 21        |  |               |               |               |               |               |               |               |               |               |
| 22        |  |               |               |               |               |               |               |               |               |               |
| 23        |  |               |               |               |               |               |               |               |               |               |
| 24        |  |               |               |               |               |               |               |               |               |               |
| 25        |  |               |               |               |               |               |               |               |               |               |
| 26        |  |               |               |               |               |               |               |               |               |               |
| 27        |  |               |               |               |               |               |               |               |               |               |
| 28        |  |               |               |               |               |               |               |               |               |               |
| 29        |  |               |               |               |               |               |               |               |               |               |
| 30        |  |               |               |               |               |               |               |               |               |               |
| 31        |  |               |               |               |               |               |               |               |               |               |
| 32        |  |               |               |               |               |               |               |               |               |               |
| 33        |  |               |               |               |               |               |               |               |               |               |
| 34        |  |               |               |               |               |               |               |               |               |               |
| 35        |  |               |               |               |               |               |               |               |               |               |
| 36        |  |               |               |               |               |               |               |               |               |               |
| 37        |  |               |               |               |               |               |               |               |               |               |
| 38        |  |               |               |               |               |               |               |               |               |               |
| 39        |  |               |               |               |               |               |               |               |               |               |
| 40        |  |               |               |               |               |               |               |               |               |               |
| 41        |  |               |               |               |               |               |               |               |               |               |
| 42        |  |               |               |               |               |               |               |               |               |               |
| 43        |  |               |               |               |               |               |               |               |               |               |
| 44        |  |               |               |               |               |               |               |               |               |               |
| 45        |  |               |               |               |               |               |               |               |               |               |
| 46        |  |               |               |               |               |               |               |               |               |               |
| 47        |  |               |               |               |               |               |               |               |               |               |
| 48        |  |               |               |               |               |               |               |               |               |               |
| 49        |  |               |               |               |               |               |               |               |               |               |
| 50        |  |               |               |               |               |               |               |               |               |               |
| 51        |  |               |               |               |               |               |               |               |               |               |
| 52        |  |               |               |               |               |               |               |               |               |               |
| 53        |  |               |               |               |               |               |               |               |               |               |
| 54        |  |               |               |               |               |               |               |               |               |               |
| 55        |  |               |               |               |               |               |               |               |               |               |
| 56        |  |               |               |               |               |               |               |               |               |               |
| 57        |  |               |               |               |               |               |               |               |               |               |
| 58        |  |               |               |               |               |               |               |               |               |               |
| 59        |  |               |               |               |               |               |               |               |               |               |
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| 61        |  |               |               |               |               |               |               |               |               |               |
| 62        |  |               |               |               |               |               |               |               |               |               |
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| 67        |  |               |               |               |               |               |               |               |               |               |
| 68        |  |               |               |               |               |               |               |               |               |               |
| 69        |  |               |               |               |               |               |               |               |               |               |
| 70        |  |               |               |               |               |               |               |               |               |               |
| 71        |  |               |               |               |               |               |               |               |               |               |
| 72        |  |               |               |               |               |               |               |               |               |               |
| 73        |  |               |               |               |               |               |               |               |               |               |
| 74        |  |               |               |               |               |               |               |               |               |               |
| 75        |  |               |               |               |               |               |               |               |               |               |
| 76        |  |               |               |               |               |               |               |               |               |               |
| 77        |  |               |               |               |               |               |               |               |               |               |
| 78        |  |               |               |               |               |               |               |               |               |               |
| 79        |  |               |               |               |               |               |               |               |               |               |
| 80        |  |               |               |               |               |               |               |               |               |               |
| 81        |  |               |               |               |               |               |               |               |               |               |
| 82        |  |               |               |               |               |               |               |               |               |               |
| 83        |  |               |               |               |               |               |               |               |               |               |
| 84        |  |               |               |               |               |               |               |               |               |               |
| 85        |  |               |               |               |               |               |               |               |               |               |
| 86        |  |               |               |               |               |               |               |               |               |               |
| 87        |  |               |               |               |               |               |               |               |               |               |
| 88        |  |               |               |               |               |               |               |               |               |               |
| 89        |  |               |               |               |               |               |               |               |               |               |
| 90        |  |               |               |               |               |               |               |               |               |               |
| 91        |  |               |               |               |               |               |               |               |               |               |
| 92        |  |               |               |               |               |               |               |               |               |               |
| 93        |  |               |               |               |               |               |               |               |               |               |
| 94        |  |               |               |               |               |               |               |               |               |               |
| 95        |  |               |               |               |               |               |               |               |               |               |
| 96        |  |               |               |               |               |               |               |               |               |               |
| 97        |  |               |               |               |               |               |               |               |               |               |
| 98        |  |               |               |               |               |               |               |               |               |               |
| 99        |  |               |               |               |               |               |               |               |               |               |
| 100       |  |               |               |               |               |               |               |               |               |               |

008058



11

11

05443890 00038121291

DATE: 12/12/91 TIME: \_\_\_\_\_

cuebox 7-3 ☐

NURSING PROCESS FLOW SHEET COMPLETED BY: \_\_\_\_\_

3-11 ☐787A Giladi  
900105710Initials signature title print name  
PLAN OF CARE REVIEWED BY: \_\_\_\_\_

Initials signature title print name

11-7N B78 A GILADI, RONI  
POB 127 NILBOURNE add needed for full information  
P. B. STRAUCH PLS  
112643264 #39 H 011-972-5334  
06443890 0003 B121291

## DATA COLLECTION

## NURSING DIAGNOSIS/PATIENT NEED/PROBLEM

| DATA COLLECTION                                     |   | NURSING DIAGNOSIS/PATIENT NEED/PROBLEM |
|---|---|--|
| S<br>E<br>N<br>S<br>O<br>R<br>Y                     | <b>COGNITIVE/PERCEPTUAL</b>   |  |
|   | Awake & Alert: Y N  |  |
|   | Oriented to Person Y N Place Y N Time Y N                                   |  |
|   | Sensory perception limitation: complete very limited slightly limited none  |  |
|   | Environment: adjust for patient Y N   |  |
|   | Pain/Discomfort: Y N  |  |
|   | If yes, describe: _____   |  |
|   | Other: _____  |  |
|   | _____   |  |
|   | _____   |  |
| C<br>I<br>R<br>C<br>U<br>L<br>A<br>T<br>O<br>R<br>Y | <b>ACTIVITY/EXERCISE</b>  |  |
|   | Heart Rate: regular irregular   |  |
|   | Chest Pain: present not present   |  |
|   | Edema: Y N  |  |
|   | If yes, describe: _____   |  |
|   | Peripheral Pulses Present: Y N  |  |
|   | If no, describe: _____  |  |
|   | Capillary refill: normal prolonged  |  |
|   | If applicable, complete: _____  |  |
|   | Cardiac monitor rhythm: _____   |  |
| Other: _____  |   |  |
| V<br>E<br>N<br>T<br>I<br>L<br>A<br>T<br>I<br>O<br>N | <b>SOB:</b> Y N   |  |
|   | Dependent on O2: Y N  |  |
|   | Cough: Y N If yes: productive non-productive                                |  |
|   | If applicable, complete: _____  |  |
|   | Trach # _____ Endotrach # _____   |  |
|   | Other: _____  |  |
|   | _____   |  |
|   | _____   |  |
|   | _____   |  |
|   | _____   |  |
| M<br>O<br>B<br>I<br>L<br>I<br>T<br>Y                | <b>Mobility:</b> completely immobile very limited slightly limited no limit |  |
|   | Transfer self 1-person/assist 2-person/lift                                 |  |
|   | Activity: walks frequently walks occasionally chairfast bedfast             |  |
|   | Gait steady: Y N  |  |
|   | Feeding: self assisted spoonfed not applicable                              |  |
|   | Other: _____  |  |
|   | _____   |  |
|   | _____   |  |
|   | _____   |  |
|   | _____   |  |

006060

003001

MONTEFIORE MEDICAL CENTER  
MOSES DIVISION  
PRE AND POST PROCEDURE PHONE CALL

SDCC-RB 900105770  
GILADI, RONI  
POB127MILBOURNE NJ07041  
B. STRAUCH PLS.  
112-64-3264 39 M 03/05/52  
06443890 0004 12/09/91

Procedure:                     Date & Time: 12-17-91Physician/Service:                     Status:                     (AMB/SDA)                     Pre-Procedure Phone Call:                     Date: 12/11Time: 11:30

Check off as completed.

1. Arrival and procedure time verification
2. NPO and medication instructions reviewed
3. No recent exposure to infections
4. Transportation/Accompanying Party
5. No change in state of health since assessment

Comments: WORK # 430-2135 Till 4:30  
missed LTC. Can't call co-workersSignature & Title                     Post Procedure Phone Call:                     Date:                     Time:                     General Status Review:                     Problems/Description                     Activity                     Nausea/Vomitting                     Increased Temperature                     Pain                     Operative Site                     Other                     Comments:                     Signature & Title                     

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MONTEFIORE MEDICAL CENTER  
MOSES DIVISION  
SAME DAY CARE CENTER

PRE PROCEDURE INSTRUCTIONS:  
(circle appropriate)

1. a. Adults: Nothing to eat or drink (not even water) after midnight, 12-11-94 (date) 12:00 (time).
- b. Pediatrics: Nothing by mouth after \_\_\_\_\_ (date).
2. a. A responsible adult must accompany you to and from the hospital.
- b. Make arrangements to be with a responsible party for 24 hours after the procedure.
3. Children must have a parent or guardian accompany them to and from the hospital, and available on the Same Day Care Center at all times.
4. Wear casual clothing.
5. Do not wear jewelry, or bring valuables to the hospital.
6. Do not wear make-up or nail polish the day of the procedure.
7. Notify your physician, or the SDCC, if symptoms of a cold, fever, or any type of infection develop.
8. Please be prompt: Arrival time and date: Between 1P-5P
9. The Same Day Care Center will notify you the day before the procedure if any changes occur in your scheduled procedure time. If you will not be home, please contact the SDCC to confirm your procedure time.
10. Other instructions:

DDO registration to Montefiore  
@ Stop At The Admit Office  
Before coming here Thursday

If you have any questions, please contact the Same Day Care Center at 212-920-5596.

I understand the above instructions:

Patient/Guardian: [Signature]

Date: 12-9-94

Relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
Signature & Title

PRINTED NAME: [REDACTED] DOB: [REDACTED] ADDRESS: [REDACTED]  
 A DIVISION OF [REDACTED] MEDICAL CENTER  
 12/9/91  
 12/12/91

PRE-EXISTING CONDITION TYPE: [REDACTED] AFFECTED: [REDACTED]  
 PROPOSED DATE/TIME: [REDACTED] AFFECTED: [REDACTED]

NAME: [REDACTED] DOB: [REDACTED] AFFECTED: [REDACTED]  
 ADDRESS: [REDACTED] AFFECTED: [REDACTED]  
 HOME PHONE: (212) 578-7697  
 AFFECTED: [REDACTED] AFFECTED: [REDACTED]

PATIENT'S NAME: [REDACTED] AFFECTED: [REDACTED]  
 ADDRESS: [REDACTED] AFFECTED: [REDACTED]

SPONSOR'S NAME: [REDACTED] AFFECTED: [REDACTED]  
 EMPLOYER: [REDACTED] AFFECTED: [REDACTED]

FATHER'S NAME: [REDACTED] AFFECTED: [REDACTED]  
 EMPLOYER: [REDACTED] AFFECTED: [REDACTED]

MOTHER'S NAME: [REDACTED] AFFECTED: [REDACTED]  
 EMPLOYER: [REDACTED] AFFECTED: [REDACTED]

\*\*\*\*\* CLINICAL INFORMATION \*\*\*\*\*

DIAGNOSIS: [REDACTED] AFFECTED: [REDACTED]  
 PROPOSED: [REDACTED] AFFECTED: [REDACTED]

DOCTOR'S NAME: [REDACTED] AFFECTED: [REDACTED]  
 ADDRESS: [REDACTED] AFFECTED: [REDACTED]  
 PHONE: (212) 578-7697 AFFECTED: [REDACTED]

\*\*\*\*\* FINANCIAL INFORMATION \*\*\*\*\*

MEDICARE: [REDACTED] AFFECTED: [REDACTED]  
 EFFECTIVE DATES: [REDACTED] AFFECTED: [REDACTED]

MEDICAID: [REDACTED] AFFECTED: [REDACTED]  
 EXPIRATION DATE: [REDACTED] AFFECTED: [REDACTED]

BLUE CROSS: [REDACTED] AFFECTED: [REDACTED]  
 ADDRESS: [REDACTED] AFFECTED: [REDACTED]  
 PHONE: (212) 578-7697 AFFECTED: [REDACTED]

BLUE CROSS: [REDACTED] AFFECTED: [REDACTED]  
 ADDRESS: [REDACTED] AFFECTED: [REDACTED]  
 PHONE: (212) 578-7697 AFFECTED: [REDACTED]

INSURANCE CO. NAME: [REDACTED] AFFECTED: [REDACTED]  
 ADDRESS: [REDACTED] AFFECTED: [REDACTED]  
 PHONE: (212) 578-7697 AFFECTED: [REDACTED]

INSURANCE CO. NAME: [REDACTED] AFFECTED: [REDACTED]  
 ADDRESS: [REDACTED] AFFECTED: [REDACTED]  
 PHONE: (212) 578-7697 AFFECTED: [REDACTED]

006064

MONTEFIORE MEDICAL CENTER - MOSES DIVISION  
DEPARTMENT OF NURSING  
DISCHARGE PLAN / INSTRUCTIONS

Admission date: 12/12/91 Discharge date: 12/13/91  
Discharged to: Home  
Allergies: N/A  
Surgical Procedure: Decompression of C6/7

900105770  
N78797A GILADI, RONI  
POB127N1LBOPHE NJ07041  
P. B. STRAUCH PLS  
112643264 addressograph information 72-5334  
06443890 00038121291

|   |  |   |   |              |
|---|--|---|---|--------------|
| I. DISCHARGE STATUS   |  |   |   |              |
| Vital signs: BP: <u>110/60</u> T: <u>98.8</u> P: <u>78</u> R: <u>20</u>   |  |   |   |              |
| Mental Status: Awake & Alert <input checked="" type="radio"/> Y <input type="radio"/> N                                   |  | Oriented to: Person <input checked="" type="radio"/> Y <input type="radio"/> N Place <input checked="" type="radio"/> Y <input type="radio"/> N Time <input checked="" type="radio"/> Y <input type="radio"/> N |   |              |
| Environment: needs adjustment: <input checked="" type="radio"/> Y <input type="radio"/> N                                 |  | describe: _____   |   |              |
| II. ABILITY TO PERFORM ADL  |  |   |   |              |
| ADL   | Self   | Assisted (including devices)  | Dependent   | Restrictions |
| Transfer  | <input checked="" type="checkbox"/>                              |   |   |              |
| Dressing  | <input checked="" type="checkbox"/>                              |   |   |              |
| Ambulating  | <input checked="" type="checkbox"/>                              | cane crutches walker w/c other  |   |              |
| Feeding   | <input checked="" type="checkbox"/>                              |   |   |              |
| Bathing   | <input checked="" type="checkbox"/>                              |   |   |              |
| Toileting   | <input checked="" type="checkbox"/>                              |   |   |              |
| Position Change   | <input checked="" type="checkbox"/>                              |   |   |              |
| Gait steady:  | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N | Bedfast:  | <input type="checkbox"/> Y <input type="checkbox"/> N | Chairfast:   |
| III. PRESCRIBED REGIMEN   |  |   |   |              |
| Diet  | <u>REG.</u>  | Comments/Restrictions   |   |              |
| Medication (name)   | dosage   | route   | time to be taken                                      |              |
|   |  |   |   |              |
|   |  |   |   |              |
|   |  |   |   |              |
|   |  |   |   |              |
|   |  |   |   |              |
|   |  |   |   |              |
|   |  |   |   |              |
| Action & Side Effects of medications were reviewed? <input type="checkbox"/> Yes  |  |   | Frequency   |              |
| Specialized Treatments  |  |   |   |              |
| IV. REFERRALS (check all that apply)  |  |   |   |              |
| <input type="checkbox"/> private M.D.   |  |   |   |              |
| name _____  |  |   |   |              |
| date: _____   |  |   |   |              |
| time: _____   |  |   |   |              |
| <input type="checkbox"/> clinic   |  |   |   |              |
| name _____  |  |   |   |              |
| date: _____   |  |   |   |              |
| time: _____   |  |   |   |              |
| <input type="checkbox"/> home care  |  |   |   |              |
| <input type="checkbox"/> VNS  |  |   |   |              |
| <input type="checkbox"/> Other: _____   |  |   |   |              |
| Return to School/Work date: _____   |  |   |   |              |
| V. WOUND/SKIN INTACT? <input checked="" type="radio"/> Y <input type="radio"/> N describe all non-intact skin             |  |   |   |              |
| <u>① Arm in SPRINT &amp; CAST - Ace wrap &amp; DSG D/T, SLUNG TO ① Arm</u>  |  |   |   |              |
| VI. MEDICAL ASSISTANCE  |  |   |   |              |
| Call for medical assistance if: <u>Temp rect drainage on DSG, numbness &amp; sensitivity to</u>                           |  |   |   |              |
| Options to obtain medical assistance in case of emergency discussed? <input checked="" type="checkbox"/> Yes <u>① Arm</u> |  |   |   |              |
| VII. STATUS OF PROBLEMS/NEEDS   |  |   |   |              |
| List unresolved problems/needs and indicate plan of care to be followed post-discharge:                                   |  |   |   |              |
| Problem/Need  | Plan of Care Post-Discharge                                      |   |   |              |
| #1 <u>PT. ALT. IN TISSUE PERFECTION</u>   | <u>Aware S/S of tissue perfusion</u>                             |   |   |              |
| #2 <u>PT. INFECTION R/T INTRUSIVE PROCEDURE</u>   | <u>Aware S/S of Infection</u>                                    |   |   |              |
| #3 <u>ALT. IN COMFORT R/T ① Arm PMA</u>   | <u>INSTRUCTED TO TAKE TYLENOL 2 tabs Q4H PRN</u>                 |   |   |              |
| #4  |  |   |   |              |
| VIII. ADDITIONAL COMMENTS/DIRECTIONS  |  |   |   |              |
| <u>Good Neuro-Vascular Status ① Arm. ① fingers slightly swollen</u>   |  |   |   |              |

YOUR DISCHARGE APPEAL RIGHTS ACCORDING TO FEDERAL AND NEW YORK STATE STATUTE ARE DETAILED ON THE BACK.  
THIS DISCHARGE PLAN HAS BEEN REVIEWED WITH ME. I HAVE RECEIVED A COPY OF THIS PLAN AND A COPY OF THE DISCHARGE APPEAL RIGHTS MECHANISM.

signature of patient or patient representative/relationship

12/13/91  
date

[Signature]  
RN signature

12/13/91  
date

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11/11  
3:30

## DEMOGRAPHICS

## ADMISSION INFORMATION

ACCT# 06443890-3 ROOM            PT CALLED IN AT            BY           

# INSURANCE

RESERVATION CLERK:

TIME: 0000



FORM ST-558

REV. 12/84

## PATIENT VALUABLES CHECKLIST

## INSTRUCTIONS FOR USE:

1. COMPLETE THIS FORM ON ADMISSION AND UPON TRANSFERS.
2. FOLLOW PROCEDURE FOR VALUABLES, WHEN APPLICABLE.
3. WHEN PERSONAL PROPERTY DOES NOT ACCOMPANY THE PT. (E.G. TRANSFER TO OR/RR), COMPLETE BOTTOM SECTION.

UNIT \_\_\_\_\_ DATE 12/12

VALUABLES ENVELOPE# \_\_\_\_\_ ITEMS TO SECURITY DEPT.: \_\_\_\_\_

PRE-ADMISSION

☐ NO CLOTHING WITH PATIENT☐ CLOTHING TAKEN HOME BY \_\_\_\_\_☐ NO VALUABLES WITH PATIENT☐ VALUABLES TAKEN HOME BY \_\_\_\_\_  
(LIST ITEMS) (SIGNATURE)☐ CLOTHING/VALUABLES RETAINED BY PATIENT (COMPLETE SECTION BELOW)☐ PATIENT MEDICATION SENT: \_\_\_\_\_

## ITEMS TO BE RETAINED BY PATIENT:

☐ MONEY (AMOUNT IF OVER \$10) \_\_\_\_\_☐ COAT☐ SHOES☐ JEWELRY (DESCRIBE) \_\_\_\_\_  
\_\_\_\_\_☐ OTHER IMPORTANT ITEMS (DESCRIBE)  
pants, shirt, underwear☐ DENTURES ( ) UPPER ( ) LOWER ( ) PARTIAL☐ EYEGLASSES ( ) PAIRS ( ) CONTACT LENSES☐ SPECIAL DEVICES/PROTHESES, AMBULATION AIDS, HEARING AIDS, WIGS  
\_\_\_\_\_  
(LIST ITEMS)\_\_\_\_\_  
(EMPLOYEE SIGNATURE & TITLE)

ADMISSION

☒ I have been advised to deposit all valuables in Admitting office safe or send them home. I accept full responsibility for anything kept at the bedside.☐ I have no valuables with me.☐ I refuse to deposit my: \_\_\_\_\_

STATE ITEM(S) \_\_\_\_\_

PATIENT SIGNATURE (OR RELATIVE OR RESPONSIBLE PARTY) \_\_\_\_\_

## DISPOSITION OF PERSONAL CLOTHING/OTHER ITEMS RETAINED BY PATIENT: UNIT: \_\_\_\_\_

☐ PATIENT TRANSFERRED VIA OR/RR. CLOTHING/PERSONAL PROPERTY SENT TO: \_\_\_\_\_ DATE: \_\_\_\_\_☐ CLOTHING/PERSONAL PROPERTY TAKEN BY RELATIVE: \_\_\_\_\_ NAME: \_\_\_\_\_ DATE: \_\_\_\_\_☐ CLOTHING/PERSONAL PROPERTY SENT TO INFORMATION DESK/SECURITY: \_\_\_\_\_ (LIST ITEMS BELOW)  
DATE: \_\_\_\_\_

DISPOSITION

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INFORMATION DESK/SECURITY SIGNATURE

EMPLOYEE SIGNATURE AND TITLE

Roni Giladi  
P.O. Box 127 Millburn, New Jersey 07041  
SS# 112 64 32 64

Tel work

212-430 2135

2/25/91 Pt. is a 39 year old ex Israeli Captain now a video photographer at Albert Einstein who on Sept. 5, 1987 had a penetrating injury to his forearm with an incomplete severance of his left median nerve. Sixteen days later he underwent a surgical repair of his nerve. Since that time the patient's sensibility has improved considerably, and though he has 8 out of 10 in all of his digits except for the second web space where he has a 6. He has almost a complete absence of sensibility of the distal portion of the long finger on the radial side. Pt's main complaint now is not sensibility but a weakness of his hand after prolonged use. On physical examination I cannot determine any loss except for that of decreased sensibility as described above. Have referred him to Dr. Berger for EMG's and conduction studies of his median and ulnar nerve.

7/19/91 Pt. return today for further evaluation. Pt. has extensive findings objectively with evidence of mild bilateral median nerve compression at the wrist and ulnar compression at the elbows. Nevertheless Pt. has aches and pains that are not compatible with compressive neuropathies, as well as an additional complexity of an upper neck injury, as well. On physical examination, Pt. has decreased sensibility, though clinically he does not report decreased sensibility - only weakness and pain. His decreased sensibility is present in the hand on all

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of his digits and Pt. has positive Tinel and positive Phelan, as well as weakness of his thenar musculature and his long flexus to the little finger. Under sterile conditions, the left carpal tunnel injected as a test to whether any improvement can be effected.

- 7/31/91 Pt. was mildly improved with the Carpal Tunnel injection. Pt. to return here in Spetember if no significant improvement and we will schedule for left median nerve decompression and ulnar nerve decompression at the elbow.
- 8/9/91 Pt. needs a letter - To Whom it May Concern - explaining that he needs a decompression of his left median nerve at the wrist and the left ulnar nerve at the elbow and wrist.
- 10/11/91 Pt. schedule for ulnar nerve transposition at the elbow, ulnar nerve release at the wrist on the left side and median nerve release. The risks benenfits and alternative of this procedure discussed fully with the pt.
- 12/11/91 Pt. is pre-op for his ulnar nerve, neurolysis of the elbow and wrist as well as neurolysis of the median nerve at the wrist. The risks, benefits and alternatives discussed fully with the pt.
- 12/18/91 Pt. comes in today with decreased sensibility of his little finger which is peculiar because he had normal sensibility up until time of discharge from the hospital. Pt. feels that perhaps he has been resting his arm on the nerve . I believe this should be a temporary phenomena. Will re-observe and re-test.
- 12/23/91 Dressing re-moved. Wound is healing well. Redressed and resplinted.
- 12/27/91 Doing well. To return in one week for removal of splint .

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Ron Giladi

## CARD II

- 1/3/92 Now 3 weeks post-surgery. Doing well. Sutures removed. Will return to work in another three weeks.
- 1/17/92 Still has some edema and inability to make a full fist. Have referred him to Ann Lang for physical therapy.
- 1/24/92 Doing well. Has a tinel in the little finger and though he has full passive range motion, cannot actively flex with great strength.
- 2/14/92 Pt. still has a stiff hand and is unable to work. To Continue working with the Hand Therapist and to return in to 8 weeks.
- 3/4/92 Pt. is doing reasonably well, able to go back to work but still needs to maintain his physical therapy.
- 3/13/92 Sensibility of the little finger is 10/5, still undergoing rehabilitation efforts to increase his ROM.
- 4/3/92 Pt. complaining of burning and pain at the elbow incision. Has good dorsal sensibility and returning sensibility of his little finger. Complains of no power or strength in his arm.
- 5/13/92 Doing well. Developing increasing sensibility of his fingers. Now has a 10/4 which affords him good protective sensibility. Sensation on the dorsum of his hand is normal. Pt. is developing increasing strength of the flexor pollicis longus tendon of the little finger. Still has some aches and pains around the elbow.

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- 7/10/92 Pt. still has difficulty using his ulnar innervated left ring and little fingers. Pt. would find it difficult if he had to be faced with a situation in a military ur
- 8/28/92 Pt. still has weakness of the ulnar innervated musculature giving him a markedly weakened grip. I do not feel that he can perform his usual army activities especial in an emergency situation where full strength capabilities of his left hand would be required.
- 10/23/92 Pt.s says he was traumatized by his ex-wife in his left upper extremity several da ago. Pt. has various aches and complaints. Have started him on Motrin 400mg TID.
- 1/15/93 Was seen in Israel where he had EMG's and Conduction studies. He was told he had a injury to his ulnar nerve at the elbow. Pt. given the original EMGs to send to Israel for comparison. Have sent him back to Dr. Berger for repeat studies here so we can compare pre-op and post-op on the same apparatus.
- 8/11/93 *Re Skov letter sent. RW*
- 10/6/93 Pt. has increasing symptoms of median nerve compression of the right wrist. I have asked him to have repeat EMG's and conduction studies of his right median nerve. May need either steroid injection or surgery.

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BERISH STRAUCH, M.D.  
PLASTIC AND RECONSTRUCTIVE SURGERY  
AESTHETIC SURGERY  
SURGERY OF THE HAND

PROFESSOR AND CHAIRMAN  
DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY  
ALBERT EINSTEIN COLLEGE OF MEDICINE  
MONTEFIORE MEDICAL CENTER

3331 BAINBRIDGE AVENUE  
BRONX, NEW YORK 10467  
TELEPHONE: 212-920-5551  
FAX: 212-798-0909

September 1, 1992  
1123 PARK AVENUE  
NEW YORK, NEW YORK 10028  
TELEPHONE: 212-534-5550

To Whom It May Concern,

Re: Ron Giladi

Mr. Giladi was originally seen in February, 1991 and gave a history of a penetrating injury to his forearm with an incomplete severance of his left median nerve in September, 1987.

At the time of my examination, he had evidence of both median nerve and ulnar nerve problems. He had both sensory and motor loss of his ulnar nerve at the region of the elbow, secondary to compression.

On December 12, 1991, he underwent a transposition of the ulnar nerve at the elbow and a release of the ulnar nerve at the Guyon's Canal. Additionally, he had a median nerve decompression and external neurolysis at the left wrist.

Post-operatively, he has done reasonably well, however, he still has weakness of the ulnar innervated musculature giving him a markedly weakened grip. I do not feel that he can perform his usual army activities, especially, in an emergency situation where full strength capabilities of his left hand would be required.

If there is any further information I can provide, I would be most happy to do so.

Sincerely,

*Berish Strauch, M.D.*  
Berish Strauch, M.D.

BS:ew  
dictated but not read

008072

11  
3/2 PM

**MONTEFIORE MEDICAL CENTER**  
**HENRY L. and LUCY MOSES DIVISION**  
**THE JACK D. WEILER HOSPITAL OF**  
**THE ALBERT EINSTEIN COLLEGE OF MEDICINE**

**CONSENT FORM**

(to be signed by patient wherever applicable)

*Ron Giladi*

PATIENT'S NAME

Date 10/11, 19 91

Time \_\_\_\_\_ A.M./P.M.

**I. PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT**

1. I hereby authorize Dr. Strach or associates or assistants of his/her choice at Montefiore Medical Center to perform upon me/the named above patient the following operation(s) and/or procedure(s)

PLEASE PRINT OR TYPE

Neurolysis & Transposition ulna nerve (2) elbow  
Neurolysis ulna nerve left wrist Neurolysis Median nerve (3) wrist

(Check if applicable) - including such photographing, videotaping, televising, or other observation of the operation(s) /procedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property of Montefiore.

2. Dr. Strach has fully explained to me the nature and purposes of the operation/procedure and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. I have been given opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
3. It has been explained to me that during the course of an operation unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) set forth in paragraph 1. I therefore authorize and request that the above named surgeon, his associates and/or assistants perform such related surgical procedures and administer whatever is necessary and desirable in the exercise of their professional judgement.
4. I have been informed that there are other risks, hazards, complications, and consequences that are attendant to the performance of any surgical procedure. I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation, treatment(s) or procedure(s).
5. I further consent to the administration of such anesthesia and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia and blood transfusions and such risks have been explained to me.
6. I further consent to disposal by hospital authorities, or possible use for research purpose, in accordance with its accustomed practice, of any tissues or parts which may be removed.
7. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

Interpreter  
if required

SIGNATURE

Patient/Relative or  
Guardian

SIGNATURE

Witness

PRINT NAME AND ADDRESS

PRINT NAME

SIGNATURE

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT

PRINT NAME

DATE

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/operation; have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian fully understand what I have explained and answered.

Physician

SIGNATURE

PRINT NAME

DATE

REMARKS:

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**MONTEFIORE MEDICAL CENTER**  
**HENRY L. and LUCY MOSES DIVISION**  
**THE JACK D. WEILER HOSPITAL OF**  
**THE ALBERT EINSTEIN COLLEGE OF MEDICINE**

**CONSENT FORM**

(to be signed by patient wherever applicable)

*Roni Giladi*

PATIENT'S NAME

Date 7/19, 19 91

Time \_\_\_\_\_ A.M./P.M.

**I. PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT**

1. I hereby authorize Dr. Strand or associates or assistants of his/her choice at Montefiore Medical Center to perform upon me/the named above patient the following operation(s) and/or procedure(s)

PLEASE PRINT OR TYPE

*Handwritten: X-ray diagnosis of Carpal Tunnel*

☐ (Check if applicable) - including such photographing, videotaping, televising, or other observation of the operation(s) /procedure(s) as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property of Montefiore.

2. Dr. Strand has fully explained to me the nature and purposes of the operation/procedure and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. I have been given opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
3. It has been explained to me that during the course of an operation unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) set forth in paragraph 1. I therefore authorize and request that the above named surgeon, his associates and/or assistants perform such related surgical procedures and administer whatever is necessary and desirable in the exercise of their professional judgement.
4. I have been informed that there are other risks, hazards, complications, and consequences that are attendant to the performance of any surgical procedure. I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation, treatment(s) or procedure(s).
5. I further consent to the administration of such anesthesia and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia and blood transfusions and such risks have been explained to me.
6. I further consent to disposal by hospital authorities, or possible use for research purpose, in accordance with its accustomed practice, of any tissues or parts which may be removed.
7. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

Interpreter  
if required

SIGNATURE

PRINT NAME AND ADDRESS

Witness

SIGNATURE

PRINT NAME

Patient/Relative or  
Guardian

SIGNATURE

PRINT NAME

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT

DATE

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/operation, have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian fully understand what I have explained and answered.

Physician

SIGNATURE

PRINT NAME

DATE

REMARKS:

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